Medicare Plans Enrollment Application

Who can use this form?

People with Medicare who want to join an Aspirus Health Plan Medicare Advantage plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area
- Have both Medicare Part A (hospital) and Medicare Part B (medical) insurance

When do I use this form?

You can join a plan:

- From Oct. 15 – Dec. 7 each year (for coverage starting Jan. 1)
- Within three months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (Oct. 15 – Dec. 7), we must receive your application by (not postmarked by) Dec. 7 for a Jan. 1 effective date
- You can choose to pay your monthly premium by check, automatic payment/electronic funds transfer (EFT) from your bank account or Social Security/ Railroad Retirement Board withdrawal

What happens next?

Send your completed and signed form to:

Attn. Sales, Aspirus Health Plan
PO Box 51
Minneapolis, MN 55440-9972

Once we process and approve your enrollment request, you will receive a confirmation letter and member ID card. Please allow time for processing.

How do I get help with this form?

- Call Aspirus Health Plan at 1.855.931.4855. TTY users call 1.855.931.4852.
- Call Medicare at 1.800.MEDICARE (1.800.633.4227) 24 hours a day/7 days a week. TTY users call 1.877.486.2048.

En español:

- Llame a Aspirus Health Plan al 1.855.931.4855. TTY 1.855.931.4852.
- Llame a Medicare gratis al 1.800.633.4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

Pre-enrollment checklist

Before making an enrollment decision, it's important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Medicare sales specialist. See Aspirus Health Plan contact information on the previous page.

Understanding the benefits

- ☐ Make sure you know the coverage and applicable deductibles, copays and coinsurance for the benefits you may need including dental, vision, hearing and other services. You can review the full list of benefits found in the Evidence of Coverage (EOC), available upon request, especially for those services for which you routinely see a doctor. Visit **medicare.aspirushealthplan.com** or call Aspirus Health Plan to view a copy of the EOC.
- ☐ Review the providers (or ask your doctor) to make sure the doctors, hospitals and facilities you see now are in the network. If they are not, it means you will likely have to select a new doctor, hospital or facility.
- ☐ Make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not, you will likely have to select a new pharmacy or may have to pay the full price for your prescriptions.
- ☐ Review the formulary online to make sure your drugs are covered: **medicare.aspirushealthplan.com/formulary**.

Understanding important rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments or coinsurance may change on Jan. 1, 2026.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers. This plan does provide worldwide emergency care.
- ☐ If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medicare Supplement/Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ You have the right to cancel your enrollment during the Medicare Advantage Open Enrollment Period from Jan 1. – March 31.
- ☐ If you need to file a complaint, you may call Aspirus Health Plan or contact Medicare at 1.800.MEDICARE.

OMB No. 0938-1378
Expires: 6/30/2026

Medicare Plans Enrollment Application

Section 1: All fields in this section are required (unless marked optional)

Plans include preventive dental coverage. You can choose to add more dental coverage to either plan below. Select the plan you want to join:

- ☐ **Aspirus Health Plan Essential Rx (PPO)** $0 per month (with Medicare Part D)
  - ☐ **Add** Aspirus Choice Dental for $29 per month
- ☐ **Aspirus Health Plan Elite (PPO)** $0 per month (no Medicare Part D)
  - ☐ **Add** Aspirus Choice Dental for $29 per month

Information about you

First name

Middle initial

Birth date (mm/dd/yyyy) / /

Last name

Sex ☐ Male ☐ Female

Permanent residence street address (cannot be a PO Box unless experiencing homelessness)

City

State

ZIP -

County

Mailing address, if different from permanent (can be street or PO Box)

City

State

ZIP -

County

Phone number - -

Email address (optional)

Your Medicare information

Medicare Number (no dashes)

Requested plan effective date (mm/dd/yyyy)

/ /

(Coverage always begins on the first of the month)

Other than Medicare, will you continue to have other coverage in addition to this plan? ☐ Yes ☐ No

If yes, select all that apply ☐ Medical coverage ☐ Prescription coverage

If other than coverage through Veterans Affairs (VA) or SeniorCare, please list

Policyholder Name

Plan name

Policy ID # Group #

Other coverage effective date (mm/dd/yyyy) / /

Attestation of eligibility to enroll

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period (AEP) from Oct. 15 through Dec. 7 of each year. There are exceptions that may allow you to enroll outside of this period. Please read the following statements and check the box if the statement applies to you. By checking the box you are certifying that, to the best of your knowledge, you are eligible to enroll. If we later determine this information is incorrect, you may be disenrolled.

Enrolling during Annual Enrollment Period (AEP)

☐ I am enrolling during AEP which runs from Oct. 15 – Dec. 7 for a Jan. 1 effective date
Note: Your application must be received by Dec. 7 for a Jan. 1 effective date

---

New or change to Medicare or your coverage

☐ I am new to Medicare Part A and Part B or I already have Part A and recently signed up for Part B

☐ I had Medicare prior to age 65 due to a disability and I'm now turning age 65

☐ I am enrolled in a Medicare Advantage plan and want to make a change to a different Medicare Advantage plan during the Medicare Advantage Open Enrollment Period (MA-OEP)
Note: This period runs from Jan. 1 – March 31 (or within your first three months new to Medicare)

☐ I was automatically enrolled in my current plan by Medicare (or my state) and want to choose a different plan
My enrollment in that plan started on (mm/dd/yyyy) / /

☐ I am moving into, live in or have recently moved out of a nursing home on
(mm/dd/yyyy) / /

A recent change in residence status

- ☐ I moved outside of the service area for my current plan within the past three months on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐ and this is a new plan for me
- ☐ I returned to the U.S. after living permanently outside of the U.S. on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I was released from incarceration on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I obtained lawful presence status in the U.S. on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

A recent change in income or Special Needs Plan (SNP) qualifications or other

- ☐ I am losing or leaving employer or union coverage and my last date of coverage is (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐ (usually the last day of the month)
- ☐ I am enrolled in a Medicare plan that is ending its contract with Medicare, or Medicare is ending its contract with my current plan
- ☐ I had a change in my Extra Help paying for Medicare prescription drug coverage (became eligible or ineligible) on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I belong to the pharmacy assistance program provided by my state (SeniorCare)
- ☐ I involuntarily lost drug coverage that is at least as good as Medicare Part D (called creditable) on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I am enrolled in my State Medicaid Program (called Medical Assistance) or am losing or lost eligibility on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I left a PACE program on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I was enrolled in a Special Needs Plan (SNP) but no longer qualify for that plan on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

If none of the statements applies to you or you're not sure, please contact Aspirus Health Plan at 1.855.931.4855 (TTY users call 1.855.931.4852) to see if you are eligible to enroll.

Section 2: All fields in this section are optional. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select if you want us to send information in a language other than English or in an accessible format:

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

☐ Email ☐ Other language or format

Plan materials are available on **medicare.aspirushealthplan.com**. Please contact Aspirus Health Plan at 1.855.935.4855 if you need information in a format other than what's listed above. Our office hours are Mon – Fri, 8 am – 8 pm. TTY users call 1.855.931.4852.

Medicare wants plans to collect the following data to better identify and address the community's needs in terms of health care access, outreach and protections against discrimination.

Are you Hispanic, Latino/a or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a or Spanish origin
☐ **I choose not to answer**

What's your race? Select all that apply.

☐ Caucasian/white
☐ Samoan
☐ Other Pacific Islander
☐ American Indian or Alaskan Native
☐ Black or African American
☐ Filipino
☐ Asian Indian
☐ Chinese
☐ Vietnamese
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Guamanian or Chamorro
☐ **I choose not to answer**

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

Section 3

Plan premium options

You can choose to pay your premium (including any late enrollment penalty that you currently have or may owe) in the following ways. Medicare requires a payment method selection even if you select a $0 premium plan. Please do not send payment with your enrollment form. Select one:

☐ Get a bill (Once enrolled, you may choose to pay by credit card, by phone or through your online Aspirus Health Plan member account.)

☐ Monthly electronic funds transfer from ☐ checking account ☐ savings account

Bank name

Bank routing #

Bank account number #

☐ Automatic monthly deduction from my

☐ Social Security (SS) ☐ Railroad Retirement Board (RRB) benefit

Note: If you have a higher income, you might pay more for your Medicare drug coverage, called a Part D Income Related Monthly Adjustment Amount (Part D – IRMAA). You must pay this extra amount in addition to your plan premium. Social Security will contact you if this applies. DON'T pay Aspirus Health Plan the Part D – IRMAA.

REQUIRED: Please read this important information and sign below.

- I must keep both hospital (Part A) and medical (Part B) insurance to stay in this plan
- By joining this Aspirus Health Plan Medicare Advantage plan, I acknowledge and agree that Aspirus Health Plan will share my information with Medicare, who may use it to track my enrollment, to make payments and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement on this form). My response to this form is voluntary. However, failure to respond may affect enrollment in this plan.
- Aspirus Health Plan may release my information for treatment, payment and operations, in compliance with state and federal law and as stated in the Notice of Privacy Practices. I acknowledge that I have read and understand Aspirus Health Plan's Notice of Privacy Practices (included in the Summary of Benefits and on **medicare.aspirushealthplan.com**).
- I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for Medicare Advantage Private Fee-for-Service (PFFS) and Medicare Medical Savings Account (MSA) plans)
- I understand that when this plan coverage begins, I must get all of my medical and prescription drug benefits from this plan. Benefits and services provided by this plan and contained in the Evidence of Coverage document (also known as member contract or subscriber agreement) will be covered. Neither Medicare nor this plan will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from this plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that: 1) This person is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request by Medicare.

Signature: _____ **Today's date:** _____

Complete this section ONLY if you are an authorized representative (e.g. agent, broker, SHIP counselor, family member, Power of Attorney or other third party) helping an enrollee fill out this enrollment application.

Name

Relationship to enrollee

If POA/Guardian, address

Phone number

- -

If Agent/Broker, your National Producer Number (NPN)

Date received (mm/dd/yyyy)

/ /

If Agent/Broker, add Primary Clinic ID# (if known)

Signature: _____

How to submit your enrollment form

Return your paper enrollment application in the enclosed postage-paid envelope to
Attn: Sales, Aspirus Health Plan, PO Box 51, Minneapolis, MN 55440-9972 or by fax at 715.787.7328.
Or enroll online at **medicare.aspirushealthplan.com/enrollment**.

Notice of Nondiscrimination

Aspirus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aspirus Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **715.631.7411 (voice)** or toll free at **1.855.931.4850 (voice)**, **715.631.7413 (TTY)**, or **1.855.931.4852 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **715.631.7411** or toll free at **1.855.931.4850 (voice)**; **715.631.7413** or toll free at **1.855.931.4852 (TTY)**.

If you believe that Aspirus Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

Oral grievance

If you are a current Aspirus Health Plan member, please call the number on the back of your membership card. Otherwise please call **715.631.7411** or toll free at **1.855.931.4850 (voice)**; **715.631.7413** or toll free at **1.855.931.4852 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance
Mailing Address
Attn: Appeals and Grievances
Aspirus Health Plan
PO Box 51
Minneapolis, MN 55440
Email: cagMA@aspirushealthplan.com
Fax: 715.631.7439

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200
Independence Avenue SW
Room 509F, HHH Building Washington, D.C.
20201
1.800.368.1019, 1.800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 715.631.7411/1.855.931.4850（TTY：715.631.7413/1.855.931.4852）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 715.631.7411/1.855.931.4850 (телетайп: 715.631.7413/1.855.931.4852).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 715.631.7411/1.855.931.4850 (**መስማት ለተሳናቸው**: 715.631.7413/1.855.931.4852).

ဟ်သူဉ်ဟ်သး–နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ် ကျိာ်အတ်မၤစၢၤလ၊ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ.
ကိး 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ៉ែរ, រសរាជំនួយរ៉ដ្ឋកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរីអ្នក។ ចូរ ទូរស័ព្ទ 715.631.7411/ 1.855.931.4850 (TTY: 715.631.7413/ 1.855.931.4852)។

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 715.631.7411/1.855.931.4850 (رقم هاتف الصم والبكم:1.855.931.4852 /715.631.7413).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 715.631.7411/1.855.931.4850 (ATS : 715.631.7413/1.855.931.4852).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/ 1.855.931.4852) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).